Integration of Comprehensive Medication Management in an ACO

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Who are we?

Heritage California ACO
Pioneer status
100K ACO lives
Part of Heritage Provider Network
Integrated care delivery
1 million lives
New York and Arizona
Shared Savings ACO’s
Blue Cross Commercial ACO
Next Generation ACO
How do ACO’s achieve triple aim?

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Principles</th>
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<tbody>
<tr>
<td>• Health care payments drive volume and not value</td>
<td>• Achieve better health, better care, lower costs for patients and communities</td>
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<tr>
<td>• Fragmented delivery system does not promote accountability for capacity, quality or costs</td>
<td>• Foster provider accountability for the full continuum of care – and for the capacity of the local health system</td>
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<tr>
<td>• Absent or poor data hinders better performance</td>
<td>• Better information that engages providers, supports improvement; informs consumers for best care</td>
</tr>
<tr>
<td>• Non-aligned payments reinforce problems, reward fragmentation, induce preventable complications, and inefficient care</td>
<td>• Pay more for better, more efficient care by aligning financial incentives with professional aims</td>
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The pharmacist’s journey
State of the profession

- Pharmacy jobs
- “looming joblessness crisis for new graduates”
- 35,000 new pharmacists by 2022
- Rated as top 5 profession
  - Forbes 2015
  - Healthcare only
- 132 Schools of pharmacy
  - 50 new schools in 30 years

- Pharmacy roles
- Industry
- Community
- Hospital
- PBM’s
- Medical Groups
- Regulatory
- Mail order
- Independent
- Government
- Education
- LTC
- ACO
Politics

- CA Senate Bill 493 – provider status in State
  - Advance Practice Pharmacist
  - Certification, Residency or providing clinical services to patients, CPA for 1 year (any 2 out of 3)
- US Senate Bill 314/House Bill 592 – “Pharmacy and medically underserved areas enhancement act” (Social Security Act revision) (MUP/A < 62 under HRSA)
- Washington – pharmacists must be added to insurance networks and paid for patient care within scope of service
  - Working on accreditation standards
- Other States
State of the universe – disruptive forces

- Dispensing technology is here
- Automated drug interaction checking technology is here
- Clinical pharmacist phone apps are here
- Pill enabled compliance monitoring technology is here
- 3D printing approved by FDA to make prescription drugs is here
- The only question left looming is “why are we here?”
Things Change
Glass half -full empty
Why are we here?
Why pharmacists in ACO?

**Transitions of Care**
- Medication Reconciliation
- Discharge Education
- Formulary Assessment
- Adherence Prediction
- Medication Assistance

**Population Management**
- Lab Monitoring
- Drug/Drug interaction
- Non-Adherence
- Treat to Target
- Addressing Care Gaps

PCP
- 10 Chronic Conditions
- 3.5 hrs vs 10.5 hrs

**Complex Disease Management**
- Disease Education
- Patient Engagement
- Treat to Target
- Care Gaps
- Focus areas:
  - ACS/CAD
  - CHF
  - Diabetes
  - HTN
  - COPD
  - ESA’s
  - HCV
- Oncology/Rare conditions
- ID
- Complex cases
Case for pharmacists in an ACO

• First step towards a sustainable healthcare delivery model
• Primary goal is to reduce costs through enhanced preventative care and disease management
• Prevent costly and avoidable re-admissions or expensive patient care encounters
• Decrease duplicative diagnostic efforts
Pharmacist care coordination/patient safety

- Risk standardized, All Condition Readmission
- Medication Reconciliation after discharge from Inpatient Facility
- Screening for fall risk
- Adherence/Care plan compliance
- Ambulatory Sensitive Conditions Admission
  - Chronic Obstructive Pulmonary Disease
  - Congestive Heart Failure
Transition of Care

• Re-packaging patient for delivery into post-hospital care system
  Special programs offered by groups – “Priority Care Clinics”
  Physician, Nurse, Pharmacist, Case Manager

• Medication Reconciliation
  Poorly done = re-admissions
  Requirement for CMS/HEDIS/ACO quality measures

• Re-admission risks associated with lack of transitional care coordination

• Incentives for post-discharge care coordination
  Hospital penalties
  Physician re-imbursement
  Patient alignment with your system
Diabetes management outcomes

<table>
<thead>
<tr>
<th></th>
<th>0 - Pre Mgmt</th>
<th>1 - 90 Days</th>
<th>2 - 180 Days</th>
<th>1 - 90 Days Post DC</th>
<th>2 - 180 Days Post DC</th>
<th>3 - 270 Days Post DC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All</strong></td>
<td>10.6</td>
<td>9.1</td>
<td>8.7</td>
<td>8.1</td>
<td>8.2</td>
<td>8.1</td>
</tr>
<tr>
<td><strong>SR</strong></td>
<td>10.5</td>
<td>9.1</td>
<td>8.6</td>
<td>8.1</td>
<td>8.1</td>
<td>8.0</td>
</tr>
<tr>
<td><strong>CM</strong></td>
<td>10.9</td>
<td>9.1</td>
<td>8.8</td>
<td>8.2</td>
<td>8.4</td>
<td>8.4</td>
</tr>
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Coincidence? Bed days/K

Total Acute Bed Days/Thousand

- 2006: 704.1
- 2008: 696.3
- 2010: 640.6
- 2012: 597
- 2014: 563.6
Quality Ratings

Average Part C Measures 2012-2014

<table>
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<tr>
<th>Average Measure</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
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<tbody>
<tr>
<td></td>
<td>4.6</td>
<td>4.8</td>
<td>4.95</td>
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Future opportunities

• Provider status
  – Tele-health

• Payment models allow for pharmacist reimbursement
  – PCM versus PBM
  – Population based global payments
  – Risk

• CMMI Demonstration projects
  – PCMH
# New Tele-health Codes

## CPT Code 99091: 30 minutes of remote patient monitoring of chronic conditions

<table>
<thead>
<tr>
<th>Medicare reimbursement</th>
<th>$56.92 monthly unadjusted non-facility fee</th>
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<tbody>
<tr>
<td><strong>Download and interpret data</strong></td>
<td>Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable)</td>
</tr>
<tr>
<td><strong>Private Insurers</strong></td>
<td>Still reimburse as a bundled service</td>
</tr>
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</table>

Since the new CPT code 99490 is an evaluation and management (E/M) code and is intended for coverage of monitoring chronic conditions, the two services (99091+99490) can now be combined as chronic care management and remote patient monitoring with a combined monthly fee of approximately $100

If combined with 99490, then CPT code 99091:
- Is no longer bundled
- Does not require face-to-face office visit
### New Tele-health codes

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<th>CPT Code 99490: 20 minutes of remote chronic care management</th>
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<tbody>
<tr>
<td><strong>Medicare reimbursement</strong></td>
</tr>
<tr>
<td>$42.60 monthly unadjusted non-facility fee</td>
</tr>
<tr>
<td><strong>Private insurers</strong></td>
</tr>
<tr>
<td>Have not acknowledged code yet</td>
</tr>
<tr>
<td><strong>Examples of non face-to-face chronic care management</strong></td>
</tr>
<tr>
<td>• Performing medication reconciliation and overseeing beneficiary’s self-management of medications</td>
</tr>
<tr>
<td>• Ensuring receipt of all recommended preventative services</td>
</tr>
<tr>
<td>• Monitoring the beneficiary’s condition (physical, mental, social)</td>
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<tr>
<td><strong>Required elements</strong></td>
</tr>
<tr>
<td>• Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient</td>
</tr>
<tr>
<td>• Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline</td>
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<tr>
<td>• Comprehensive care plan established, implemented, revised, or monitored</td>
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<tr>
<td><strong>Eligible personnel</strong></td>
</tr>
<tr>
<td>• Licensed clinical staff (Physician, APRN, PA, RN, LSCSW, LPN, medical technical assistants)</td>
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<tr>
<td>• The physician or other practitioner does not have to be the same person under whose name the CCM is billed (can even contract with a third party)</td>
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<tr>
<td><strong>EHR requirements</strong></td>
</tr>
<tr>
<td>Billing provider does not need to demonstrate meaningful use, but must have a “CCM certified technology” (satisfies either 2011 or 2014 EHR Incentive Programs certification criteria). Can use “some form of EHR technology tool or services in fulfilling the care plan element,” which does not need to be certified</td>
</tr>
<tr>
<td><strong>Beneficiary must have access to a member of the care team on a 24/7 basis to address acute/urgent needs in a timely manner</strong></td>
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Take Home Points

• Innovation is what occurs prior to change being forced upon you
• Pharmacists move up the food chain (PCP shortage requires innovative care models)
• Transitional care coordination requires all providers to participate
• ACO’s to date have demonstrated both cost savings and patient care experience improvement
• More change coming – Managed Medi-Cal, Duals, SNP
• Triple aim success = here to stay for all care delivery